2024/25 Quality Improvement Plan
"Improvement Targets and Initiatives"

Bruyere Continuing Care Inc. 43 Bruyere Street, Ottawa , ON, K1N5C8

AIM		Measure									Change				
Issue	Quality dimension	Measure/Indicator	Type	Unit / Population	Source / Period	Organization Id	Current performance	Target	Target justification	External Collaborators	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Target for process measure	Comments
M = Mandatory (all cells must be completed) P = Priority (complete ONLY the comments cell if you are not working on this indicator) O= Optional (do not select if you are not working on this indicator) C = Custom (add any other indicators you are working on)															
Access and Flow	**Efficient**	Alternate level of care (ALC) throughput ratio	O	Ratio (No unit) / ALC patients	WTIS / July 1 2023 - September 30, 2023 (Q2)	932*	0.8	0.80	Opening additional transitional bed		1)Continued adherence to the Home First Philosophy	Weekly Joint Discharge Review (JDR) meetings to discuss new and existing ALC cases	Percentage of new ALC cases presented at JDR	100% of new ALC cases discussed at JDR, as well as regular review of existing ALC patients is the is the target for the process measure	
											2)Optimization of transitional beds	Optimizing use of TC beds so ALC patients in high and low intensity rehab are transitioned there as rapidly as possible so the rehab services can admit the next patient from acute care.	Optimize the process of transfers from interval programs to the transitional beds	Optimization of transitional beds is complete	
Experience	**Patient-centred**	Discharge Experience: Overall Discharge experience	C	% / Discharged patients	In house data collection / 2024-2025	932*	65.7	66.80	2.5% Improvement over current performance (up to January 2024)		1)Bruyere @home program.	Bruyere @Home program available to all hospital in-patients eligible for their services	Percentage of patients referred to @ home program discharged within 2 days of their expected discharge date.	90% of discharges met discharge date.	
											2)Hospital to Home Patient Experience Program	Quality coordinators to work with STCM/Geriatric rehab and stroke rehab to review current H2H PEP data to identify 1 targeted opportunity to improve discharge experience	Percentage of STCM/Geriatric/Stroke rehab programs that have implemented a patient discharge experience QI project	100% is the target for process measure	
		Patient experience: Would you recommend this hospital to family or friends if they needed this type of care?	C	% / All inpatients	In house data collection / 2024-2025	932*	81.3	84.20	2.5% Improvement over current performance (up to January 2024)		1)Continue to introduce Nursing Always Practices during orientation and onboarding including BSSR, careboards, safety huddles, and focused rounding.	Education on Nursing Always Practices is provided to newly hired nurses during orientation and during buddy shifts.	Percentage of newly hired nursing staff	100% is the target for process measure	
											2)Establishment of Nursing Always Practices Steering Committee with primary focus on sustainability strategies including a) Supporting facilitation of safety huddles b) Addressing barriers of bedside shift report	a) Level 3 at EBH is piloting patient assignment making where the staff on the current shift prepares assignment for the oncoming shift. b)NPP and QPR will collaborate in creating a tip sheet for the CMs on facilitating safety huddles in a time efficient manner	a) Quarterly targets to ensure assignments are ready before the beginning of the shift. b) Quarterly audits are performed by NPP for assuring adherence to the BSSR practices and providing just-in-time education to clinical staff as well as percentage of patients who respond always to the question "Do you see your nurse on a regular basis? in the patient experience survey.	a) 85% is the target for the process measure b)85 % target for process measure for audits and 66.73% target for process measure for the survey question results	
											3)Care boards as a tool for communication	Continue training and education on use of care boards in hospital programs	Quarterly care board audits	80% is the target for the process measure	
											4)Leader rounding with patients	Clinical Managers to round on patients	Percentage of managers rounding on patients	Target for process measure: 90% of clinical managers will meet their program specific target for rounding with patients	
											5)All programs to review current patient experience data to identify 1 targeted opportunity to improve patient experience	Quality Coordinators to work with the program/unit to identify areas for improvement and roll out a formal quality improvement project.	Percentage of programs/units that have implemented a patient experience QI project	100% is the target for process	
		Percentage of residents who responded positively to: "I participate in meaningful activities"	C	% / LTC home residents	In house data, interRAI survey / 2024-2025	51651*	48	48.00	In the last three quarters, RSL remained above the previously set target. RSL's average indicates		1)Maintain adjusted staffing hours to offer evening and weekend activities and continue with recruitment efforts for volunteers	1.1) Welcome students 1.2) Sustain volunteering recruitment efforts	1.1) Welcome various types of students (e.g. Therapeutic Recreation Services, Co-op, partnerships) 1.2) Total number of volunteer hours	1.1) Welcome at least 3 students 1.2) 10% increase in total number of volunteer hours	

									improvement and the team would like to see this be maintained. Therefore the new fiscal year's target will be 48% to reflect the average of the last three quarters.		2)Offer more opportunities for meaningful group sessions with Spiritual Care	Sustain current state and create new opportunities for monthly Spiritual Care led group activities	Number of Spiritual Care led group activities per month, develop and trial a monthly group activity to remember residents who have passed in addition to enhancing and bringing back a larger celebration of life activity	Offer 24 group activities per month led by Spiritual Care, develop and trial a new memorial activity for a minimum of 3 months, and re-launch at least one larger celebration of life activity	
											3)Sustain resident skill and interest groups and increase external outings	Create a list of opportunities for external outings during the year	Number of external outings per year	Organize 4-6 external outings	
											4)Enhance monthly survey collection and data review process	Collect resident quality of life data gradually throughout the entire year	4.1) % of residents who respond positively that they have enjoyable things to do in the evenings. 4.2) % of residents who respond positively that they have enjoyable things to do on weekends. 4.3) % of residents who respond positively that they participate in religious activities that have meaning to them. 4.4) % of residents who respond positively that they have the opportunity to explore new skills and interests.	4.1) Evening activities (same target): 36% 4.2) Weekend activities (average): 28% 4.3) Participate in religious activities that have meaning to them (average): 79% 4.4) Skills & interests (same target): 20%	
											5)Integrate physio exercise classes into the activity calendar and run consistently	Include in activity calendar and ensure sufficient resources for portering, etc.	5.1) Number of physio group exercises on the activity calendar 5.2) Number of physio group exercise classes conducted	5.1) 2 classes per home area on the activity calendar 5.2) 2 classes per home area conducted consistently (unless exceptional circumstances)	
		Percentage of residents who responded positively to: "I participate in meaningful activities"	C	% / LTC home residents	In house data, interRAI survey / 2024-2025	53536*	51	48.00	In the last two quarters where data was obtained, REB remained above the previously set target. REB's average indicates improvement, however, a large variation was noted between both quarters. Also, given the limited data at REB, the average from RSL was utilized and the team would like to see the improvement be maintained. Therefore the new fiscal year's		1)Maintain adjusted staffing hours to offer evening and weekend activities and continue with recruitment efforts for volunteers	1.1) Welcome students 1.2) Sustain volunteering recruitment efforts.	1.1) Welcome various types of students (e.g. Therapeutic Recreation Services, Co-op, partnerships) 1.2) Total number of volunteer hours	1.1) Welcome at least 2 students 1.2) 10% increase in total number of volunteer hours	
											2)Offer more opportunities for meaningful group sessions with Spiritual Care	Sustain current state and create new opportunities for monthly Spiritual Care led group activities	Number of Spiritual Care led group activities per month, develop and trial a monthly group activity to remember residents who have passed in addition to enhancing and bringing back a larger celebration of life activity	Offer 12 group activities per month led by Spiritual Care, develop and trial a new memorial activity for a minimum of 3 months, and re-launch at least one larger celebration of life activity	
											3)Sustain resident skill and interest groups and increase external outings	Create a list of opportunities for external outings during the year	Number of external outings per year	Organize 4-6 external outings	

									target will be 48% to reflect the average of the last three quarters at RSL which is near the average of the two fluctuating quarters of data at REB.		4)Enhance monthly survey collection and data review process	Collect resident quality of life data gradually throughout the entire year	4.1) % of residents who respond positively that they have enjoyable things to do in the evenings. 4.2) % of residents who respond positively that they have enjoyable things to do on weekends. 4.3) % of residents who respond positively that they participate in religious activities that have meaning to them. 4.4) % of residents who respond positively that they have the opportunity to explore new skills and interests.	4.1) Evening activities (AVERAGE of: RSL average of 21% + REB average of 58%): 40% 4.2) Weekend activities (AVERAGE of: RSL average of 28% + REB average of 42%): 35% 4.3) Participate in religious activities that have meaning to them (AVERAGE of: RSL average of 79% + REB average of 68%): 74% 4.4) Skills & interests (same target as last year): 25%	
											5)Integrate physio exercise classes into the activity calendar and run consistently	Include in activity calendar and ensure sufficient resources for portering, etc.	5.1) Number of physio group exercises on the activity calendar 5.2) Number of physio group exercise classes conducted	5.1) 2 classes per home area on the activity calendar 5.2) 2 classes per home area conducted consistently (unless exceptional circumstances)	
Safety	**Effective**	Patient falls (for every 1000 patient days)	C	% / All inpatients	In house data collection / 2024-2025	932*	3.86	3.80	The absolute target is remaining the same but is in fact an improvement as we are opening additional transitional care beds which have		1)Programs to roll out program specific targeted falls intervention. e.g fall prevention huddles and introduction of toileting programs	Programs where falls are above target will review available falls intervention strategies and identify a priority intervention for the program. Fall prevention huddles have been adopted by 2-South, 3 North, and PCU. The results will be presented to other programs to spread the model 2. 3 North and 2 BD are focusing on patient toileting as incontinence is one of the risk factors for falls.	Percentage of programs/units where falls rate are above target that have implemented targeted falls interventions	100% is the target for units that are above target process	
	Safe	Percentage of LTC residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment	O	% / LTC home residents	CIHI CCRS / July 2023–September 2023 (Q2 2023/24), with rolling 4-quarter average	51651*	23.11	21.00	In the last four quarters, RSL was unable to meet the target. Therefore the target will remain the same.		1)Sustain data flagging, sharing and identifying appropriate residents for deprescribing	Reports and audits	Conduct audits on all resident who are prescribed antipsychotics and share report with designated team members	Monthly audits and a minimum of 2 reports sent quarterly to designated team members	
											2)Sustain regular interdisciplinary meetings to discuss residents who could be candidates for deprescribing and plan accordingly	Organize interdisciplinary discussions to review opportunities to begin or continue gradual dose reduction, create enhanced care plans with non pharmaceutical interventions, as appropriate, and deprescribe accordingly	Conduct regular interdisciplinary discussions via different forums	Regular interdisciplinary reviews	
											3)Research and develop appropriate assessment and process for deprescribing	Conduct research on available resources and contact external experts	Develop and research an appropriate assessment and process for deprescribing	Information gathering completed and outline of process developed	
		Percentage of LTC residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment	O	% / LTC home residents	CIHI CCRS / July 2023–September 2023 (Q2 2023/24), with rolling 4-quarter average	53536*	28.46	26.00	In the last four quarters, EBR was unable to meet the target. Therefore the target will remain the same.		1)Sustain data flagging, sharing and identifying appropriate residents for deprescribing	Reports and audits	Conduct audits on all resident who are prescribed antipsychotics and share report with designated team members	Monthly audits and a minimum of 2 reports sent quarterly to designated team members	
											2)Sustain regular interdisciplinary meetings to discuss residents who could be candidates for deprescribing and plan accordingly	Organize interdisciplinary discussions to review opportunities to begin or continue gradual dose reduction, create enhanced care plans with non pharmaceutical interventions, as appropriate, and deprescribe accordingly	Conduct regular interdisciplinary discussions via different forums	Regular interdisciplinary reviews	
											3)Research and develop appropriate assessment and process for deprescribing	Conduct research on available resources and contact external experts	Develop and research an appropriate assessment and process for deprescribing	Information gathering completed and outline of process developed	

	Fall rate per 1000 resident days	C	% / LTC home residents	In house data collection / 2024-2025	53536*	4.1	3.90	The facility level targets were developed from the home area level fall targets. Each home area level fall targets were based on the 2023 results where home areas could meet their individual targets at least 50% of the time. We are assuming home area level occupancy for 24-25 will remain constant to what has taken place in 23-24.		1)Maintain the monthly fall target reporting and engagement of staff	Involve interdisciplinary team through meetings and committees	Monthly target reports shared to assess current status and discussions organized with the teams when the target is surpassed	12 monthly fall target reports and confirmed meetings held with the teams that don't meet their targets	
										2)Sustain the interdisciplinary fall review discussions and outline frequency and membership	Targeted regular interdisciplinary meeting	Maintain a minimum of one interdisciplinary meeting per quarter to review residents who fall frequently	Minimum of 4 targeted interdisciplinary meetings over the year with proper charting documentation	
										3)Conduct a needs assessment for the visual symbol on rooms of residents at high risk of falls and action accordingly	Determine the need to use the visual symbols and plan accordingly to standardize who is responsible for putting up and taking down the fall visual symbol and timeframe to do so	Make a decision on implementation or not of the fall visual symbol, and develop a process with responsibilities and expectations around it accordingly	Decision made and process designed with responsibilities and expectations around the fall visual symbol defined to meet 100% of the designated rooms identified accordingly if team choses to implement	
	Falls per 1000 residents days	C	% / LTC home residents	In house data collection / 2024-2025	51651*	7.6	6.80	The facility level targets were developed from the home area level fall targets. Each home area level fall targets were based on the 2023 results where home areas could meet their invididual targets at least 50% of the time. We are assuming home area level occupancy for 24-25 will remain constant to what has taken place in 23-24.		1)Maintain the monthly fall target reporting and engagement of staff	Involve interdisciplinary team through meetings and committees	Monthly target reports shared to assess current status and discussions organized with the teams when the target is surpassed	12 monthly fall target reports and confirmed meetings held with the teams that don't meet their targets	
										2)Sustain the interdisciplinary fall review discussions	Targeted regular interdisciplinary meeting	Maintain a minimum of one interdisciplinary meeting per month to review residents who fall frequently	Minimum of 12 targeted interdisciplinary meetings over the year with proper charting documentation	
										3)Enhance care conferences	Standardize care conferences	Design and implement a standardized process for care conferences	Care conference process designed and implemented	
										4)Maintain the visual symbol on rooms of residents at high risk of falls or followed by the fall squad and improve the process	Standardize who is responsible for putting up and taking down the fall visual symbol and timeframe to do so	Design a process with responsibilities and expectations around the fall visual symbol	Process designed with responsibilities and expectations around the fall visual symbol defined to meet 100% of the designated rooms identified	
	Percentage of residents who developed a stage 2 to 4 pressure ulcer or had a pressure ulcer that worsened to a stage 2, 3 or 4 since their previous resident assessment	C	% / LTC home residents	CIHI MDS data / 2024-2025	51651*	7.3	6.50	In the last four quarters, RSL was below target in only the most recent quarter. Although trending down, RSL's average of the last four quarters is above the target from the last fiscal year. A 10% improvement from RSLs average in the last four quarters would give 6.57%. The team believes remaining at a target of 6.5% at RSL would be beneficial as the target has only		1)Maintain the monthly PURS reporting (with help from MDS) and engagement of staff	Involve interdisciplinary team through meetings and committees	Monthly reports shared to assess current status and discussions organized with the leadership team	12 monthly reports and minimum 10 meetings held with the leadership team to discuss raw data	
										2)Sustain the interdisciplinary pressure injury review discussions	Targeted regular interdisciplinary meeting and audits	Maintain a minimum of one interdisciplinary meeting per month to review residents who have or are at high risk of pressure injuries	Minimum of 12 targeted interdisciplinary meetings over the year with proper charting documentation	
										3)Re-design the Skin and Wound e-module	Material review and updating	Re-design the Skin & Wound e-module	E-module on Skin & Wound redesigned and launched	
										4)Plan the process for the visual symbol on rooms of residents at high risk of pressure injuries followed by the wound squad	Develop a process for who is responsible for putting up and taking down the pressure injury symbol and timeframe to do so	Design a process with responsibilities and expectations around the pressure injury visual symbol	Process designed with responsibilities and expectations around the pressure injury symbol	

		Percentage of residents who developed a stage 2 to 4 pressure ulcer or had a pressure ulcer that worsened to a stage 2, 3 or 4 since their previous resident assessment	C	Months / LTC home residents	CIHI MDS data / 2024-2025	53536*	3.7	3.70	In the last four quarters, EBR remained below target in all four quarters. EBRs average in the last four quarters is quite low and the team would like to see this be maintained. Therefore the new fiscal year's target will be 3.7% to reflect the average of the last four quarters.		1)Maintain the monthly PURS reporting (with help from MDS) and engagement of staff	Involve interdisciplinary team through meetings and committees	Monthly reports shared to assess current status and discussions organized with the leadership team	12 monthly reports and minimum 10 meetings held with the leadership team to discuss raw data	
											2)Initiate the interdisciplinary pressure injury review discussions	Targeted regular interdisciplinary meeting and audits	Facilitate a minimum of one interdisciplinary meeting per quarter to review residents who have or are at high risk of pressure injuries	Minimum of 4 targeted interdisciplinary meetings over the year with proper charting documentation	
											3)Re-design the Skin and Wound e-module	Material review and updating	Re-design the Skin & Wound e-module	E-module on Skin & Wound redesigned and launched	
		Percentage of staff and provider burnout.	C	% / Staff and provider	Employee Wellness Survey / 2024-2025	91397*	CB	CB	Currently in the process of rolling out a staff and provider wellness survey.		1)Identify opportunities to reduce administrative burden. Identify opportunities to improve workflow through use of EMR and/or virtual tools. Identify opportunities to recognize staff and providers. Increase opportunities for interdisciplinary case conferences for providers and staff; target is for those who are supporting a select sample of patients who use multiple FHT resources frequently	Develop simplified EMR tools. Implement online appointment booking. Implement improved phone system. One on one rounding with staff. Share recognition notes individually and collectively. Schedule interdisciplinary case conferences.	% direct reports have had completed one on one rounding annually. # recognition notes sent annually. # interdisciplinary case conferences annually.	90% direct reports will have one on one rounding annually. 5 or more recognition notes monthly. 8 interdisciplinary case conference annually.	
		Percentage of staff and providers performing hand hygiene on moment 1.	C	% / Staff, providers and learners	In house data collection / 2024-2025	91397*	90	95.00	Maintain and/or improve. Main goal to implement a process for ongoing monitoring		1)Increase availability of alcohol based hand rub (ABHR) Increase passive and active cuing. Engage patient involvement with active cuing.	Trial use of new audit tool. Trial use of patient reporting tool identifying hand hygiene moments performed. Audit of sanitizer locations. Publicly share more frequently hand hygiene compliance rates with staff, providers and patients.	% staff, providers and learners compliant with hand hygiene moments 1	95% for moment 1	Patient Partner Committee highlighted this as a recommended QIP indicator
		Percentage of staff and providers performing hand hygiene on moment 4.	C	% / Staff, providers and learners	In house data collection / 2024-2025	91397*	97	95.00	Maintain and/or improve. Main goal to implement a process for ongoing monitoring		1)Increase availability of alcohol based hand rub (ABHR). Increase passive and active cuing. Engage patient involvement with active cuing.	Trial use of new audit tool. Trial use of patient reporting tool identifying hand hygiene moments performed. Audit of sanitizer locations. Publicly share more frequently hand hygiene compliance rates with staff, providers and patients.	% staff, providers and learners compliant with hand hygiene moment 4	At least 95% for moment 4	Patient Partner Committee highlighted this as a recommended QIP indicator